# Recognising the value of a bunch of tulips in general practice

*'How are you doctor? I was sorry to hear you'd been unwell.'*

I looked across at the woman sitting across from me.* A surgical mask obscured her face above the angry scar on her neck but her eyes were smiling and kind, tinged with real concern. I had a packed day of emotionally-intense patients and my head was full of heart-wrenching tales of Ukrainian refugees, messages from colleagues about work, and anxieties about finding last-minute patients to teach medical students tomorrow. Really, I just wanted to go back to bed! I smiled back at her, invisible behind my mask, and touched her arm, *'That's so kind. Not so bad. How are you?'*

I read Dr Gerada's article (www.theguardian.com/society/2022/feb/22/my-30-years-as-gp-profession-horribly-eroded-clare-gerada) with great sadness. In it she mourns the 'horrible erosion' of general practice, describing medically complex patients whose care is complicated by poor communication between services and reduced community support, the frustrating expectations of centralised 'call centres', and the relentless workload — all horribly familiar. Above everything, she laments the decline of personal relationships with patients and the shame and helplessness that arise from their absence.

Like Dr Gerada, I too am the daughter of a GP. The local practice was my second home and I remember my mum's on-call 'in-and-out weekends' when I would long for more 'ins' than 'outs'. Like Dr Gerada, my mother was my inspiration, role model, and teacher. Unlike Dr Gerada, I am at the outset of my general practice career. However, I too am a 'traditional' GP. I believe in relationships and continuity of care with my patients. I still believe, perhaps naively and despite the challenges, that these can be achievable today.

## EARLY DREAMS

As I finished medical school I was going to be a hand surgeon. I loved the creativity and ability to 'fix' people. There was nothing more satisfying than relieving the pain of an infected finger. Restoring function to the part of a person that allows them to 'do what they do' and so 'be who they are' made my heart sing. But I hated the long operations and missed the 'human' part of medicine.

Returning to general practice felt like coming home. For 12 months I concentrated on exams and building relationships with 'my' patients. Then COVID-19 struck and overnight, I became isolated. In the initial panic staff mixing was restricted, social distancing enforced, and all appointments became remote. As the first lockdown began to bite and our nursing home death tolls rose, I was passing days without face-to-face contact with another human. Never have I been lonelier.

While the trauma and agonies of hospital staff cannot be overstated, most COVID-19 cases never reached hospital. Primary care teams coped with these patients, those who could not be referred and languish on waiting lists, conducted normal activities, and undertook much of the vaccination programme — all while continually readjusting systems in response to national policies and media pressure. With increasing pressure on appointments and reduced opportunities for face-to-face contacts it has been harder, particularly for newer GPs, to provide the reassurance of relationship-based care, resulting in a sense of helplessness, fatigue, and anger about the support we are offering.

*This* is the frustration in Dr Gerada's article. This is not the general practice of my childhood — and I hope not the general practice of the future.

The current challenges are stark. In real terms the GP workforce is declining and demand escalating, vastly outstripping funding. An increasingly complex evidence-base underlies clinical decision making while the national policy direction frequently lies against localised autonomy, resulting in 'one-size-fits all' directives — hindering development of services to meet specific local needs. GPs are frequently left carrying the risks and uncertainties for system inadequacies and the associated stress. Technological developments and multidisciplinary working can be great — if appropriately deployed and resourced, but deciding on the core elements of general practice truly valued by patients and GPs and strengthening these, while reluctantly letting go of others, is currently essential. What matters is transparency about the alternatives and the compromises we are forced into by funding, staffing, and system limitations.

GPs are also human and the pressures are increasing. The possibility for work–life balance and portfolio career options attract doctors and add richness and wealth to our practice. I value my colleagues' work in psychiatry or women's health and, while it is frustrating for patients not to have their preferred doctor always accessible, these additions allow us to flourish and sustain our GP roles. We should be honest about this.

Unlike Dr Gerada, I am not despondent. I understand patients' experiences have suffered recently but I still believe in the potential of our profession and I am still proud to be a GP.

As she stood up to leave my patient asked, *'Have you had the results from the operation samples? I haven't heard anything.' 'Oh'*, I said, surprised, *'No, but let me check.'*

She sat, anxiously, hands tightly gripping her bag. The results appeared and my blood pressure rose. I really didn't want to have to tell her the cancer had spread. *'No evidence of metastatic carcinoma'*, I read out loud, turning the screen so that she too could read it. I felt a lump rise in my throat.

*'Oh'*, she said, her voice catching, *'Oh. That's good news.'* Our eyes met, above our masks. All of them were shining.

As I left that evening I found a bunch of tulips at reception. *'Thank you'* the note simply read.

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